DELTA DENTAL®

Delta Dental of Minnesota
Serving North Dakota

North Dakota Small Business Client Employer Application

DeltaVision®

PART A – Client Information

Plan Effective Date _____ Plan Type ☐ Dental ☐ Vision ☐ Dental + Vision

Legal Company Name _____

Physical Address _____ Phone (____) _____

City _____ State _____ Zip Code _____

Mailing Address ☐ Same as client physical location _____

City _____ State _____ Zip Code _____

Total Number of Eligible Employees _____

Client Contact Information

First Name _____ Last Name _____

Title _____

Contact Type ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials ☐ Overage Dependent

Phone (____) _____ EXT _____ Cell (____) _____

Email Address _____

Mailing Address ☐ Same as client physical location _____

City _____ State _____ Zip Code _____

Additional Client Contact Information (if applicable)

First Name _____ Last Name _____

Title _____

Contact Type ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials ☐ Overage Dependent

Phone (____) _____ EXT _____ Cell (____) _____

Email Address _____

Mailing Address ☐ Same as client physical location _____

City _____ State _____ Zip Code _____

Client – Employer Services Portal Registration

With the Employer Services Portal, you can enroll a new member, update existing members, view eligibility and dental and vision plan benefits. In addition, your monthly invoice and other billing details are provided to you exclusively through the Employer Services Portal.

Select a Client Super User within your company and complete the information below. This Client Super User will create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will email the Client Super User with registration information and additional instructions.
The Client Super User must be an employee of the company.

Client Super User Name _____ Title _____

Email Address _____ Phone (____) _____

Continued

PART B - Dental Plan Options (choose only one)

Available for groups with 2 - 100 eligible employees, a minimum of 2 employees must enroll.
All dental plans below utilize the Delta Dental PPO™ Plus Premier® network.
Waiting periods are applicable, unless otherwise indicated. Waiting periods may also be waived with twelve (12) months of prior comparable coverage for all initial enrollment on plan effective date.

Does your company currently have a dental plan? ☐ No ☐ Yes*

*If yes, please include a copy of the most recent billing statement and benefit summary.

Name of Carrier _____ Prior Plan Start Date _____

☐ **Solutions 1000, 1500, 2000:**

Annual Plan Maximum Options - *Please check (✓) one below:*

- ☐ $1,000 per person, per year - with child orthodontic coverage
- ☐ $1,500 per person, per year
- ☐ $2,000 per person, per year - with child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Dental Flex:**

Annual Plan Maximum Options - *Please check (✓) one below:*

- ☐ $1,000 per person, per year
- ☐ $1,000 per person, per year - with child orthodontic coverage
- ☐ $1,500 per person, per year
- ☐ $1,500 per person, per year - with child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Pathfinder 1 - 5:**

Plan Options - *Please check (✓) one below:*

- ☐ Pathfinder 1
- ☐ Pathfinder 2
- ☐ Pathfinder 3
- ☐ Pathfinder 4
- ☐ Pathfinder 5 - with child orthodontic coverage - plan waiting periods do not apply

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

Continued

PART C – DeltaVision® Plan Options (choose only one)

Available for groups with 2 - 100 eligible employees, a minimum of 2 employees must enroll.
All vision plans below utilize the DeltaVision® Insight network.

Does your company have a Delta Dental of Minnesota dental plan? ☐ No ☐ Yes*

*If yes, please provide Client Number (if available) _____

Please refer to your DeltaVision® proposal:

- When combining DeltaVision® with a Delta Dental policy, you will automatically receive the discounted DeltaVision® rates.
- If you are electing a standalone DeltaVision® policy, your plan rates are determined by the selected Employer Contribution below.

☐ **Combined Delta Dental and DeltaVision®**

☐ **Standalone DeltaVision®**: Employer Contribution 80 - 100%

☐ **Standalone DeltaVision®**: Employer Contribution 0 - 79%

☐ **DeltaVision®:**

Plan Options - *Please check (✓) one below:*

☐ DeltaVision® 150 Materials Only

☐ DeltaVision® 200 Materials Only

☐ DeltaVision® 200

Please confirm sold plan rates

Employee _____

Employee + Spouse _____

Employee + Child(ren) _____

Family _____

PART D – Premium Remittance and Submission

Payment Method - *Please check (✓) one below:*

☐ **ACH** - *Include a completed Direct Debit Authorization (ACH) Form*

☐ **Check** - *Include a check made payable to **Delta Dental of Minnesota** and mail to:*

Delta Dental of Minnesota NW5772 P.O. Box 1450 Minneapolis, MN 55485-5772

1. Complete this Employer Application. Retain a copy for your files.
2. Have each employee complete and sign an Enrollment Form or be identified on the Delta Dental approved Enrollment spreadsheet completed by the Client Administrator.
3. Email the Employer Application, completed Enrollment Forms or the approved Enrollment spreadsheet, ACH Form (if applicable), and corresponding Dental and/or Vision Proposal to: DeltaDentalConnect@DeltaDentalMN.org

For questions call 1-800-906-5250 option 2 or email us at DeltaDentalConnect@DeltaDentalMN.org

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PART E – Client Administrator

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the Company (Company as named in Part A above) and agree to provide substantiating evidence when requested.

If Delta Dental and/or Health Ventures Network accepts this application, Delta Dental and/or Health Ventures Network will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental and/or Health Ventures Network. If issued, the contract may become null and void at the option of Delta Dental and/or Health Ventures Network if for a period of three consecutive months, or upon renewal, the number of enrolled employees does not meet the participation requirements.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

This application does not guarantee coverage.

The first month's premium payment must be received in order for Delta Dental to pay claims for your members.

DeltaVision® is a Registered Mark of Delta Dental Plans Association

Network Administrator: EyeMed, underwritten by Health Ventures Network

Authorized Company Official _____ **Title** _____

Phone (____) _____ **Email Address** _____

_____ _____

Signature of Authorized Company Official **Date**

PART F – Broker of Record - Completion of all fields is required

Broker Name _____ **Agency** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone (____) _____ **Email Address** _____

_____ _____

Broker Signature/Insurance Broker License ID Number **Tax ID Number**
Note: Commissions will be paid to this TIN

Broker Services Portal

With the Broker Services Portal, the Broker of Record can update and view the client's eligibility and access the client's billing details. The Broker/Agency will work with their Agency's Broker Super User, who will add the appropriate user permissions to the Broker's access.